Provision of community child health care—an acute problem

SIR,—General paediatrics in the main is inevitably and fortunately becoming a community specialty. Areas of consultation vary from schools, welfare clinics, and GP surgeries, through to hospital outpatient departments. Dr Allan F Colver (13 March, p 819) states that in the case of acute illness families choose either the child health clinic or the GP. This may be so for the majority of families, but there are still an unacceptable number of parents who for various reasons choose to bypass the so-called primary health care team, as discussed by Drs L Peter and H B Valman (6 March, p 725), and "self-refer" themselves to hospital casualty departments.

The reasons vary from innocent ignorance on the part of, say, new overseas immigrants on one hand to downright defiance of sensible advice given by the family doctor on the other. Whatever the reason, the problem remains for the on-call hospital team. What do you do at two o'clock in the morning with a baby of 11 months brought to you directly with an upper respiratory tract infection, not uncommonly via an ambulance? In your opinion the child does not really warrant admission, yet the parents have no transport home, and in any case if they have not had the confidence to have the child at home in the first place, could they be trusted to carry out your instructions on sending the child away? Added to this is the complication of the parents leaving one hospital to immediately seek admission at another nearby, which has happened to me personally on at least two occasions.

I suppose the only way in which we can avoid or deal with this problem is to have a closer liaison with the agencies involved. I would dearly love prior warning of likely "self-referred" problems from the family doctor. On the other hand, I would welcome better facilities of transport home for these cases and easier access to the GP, priming him in his turn of possible sources of activity for the night.

Surely the debaters on the provision of community child health services, who have contributed to this journal recently (13 March, p 819; 6 March, p 725; 27 February, p 637; 6 March, p 717, and 13 March, p 820), can offer some solution?

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Therapeutic control of anticoagulant treatment

SIR,—It is possible that oral anticoagulant therapy may be increasingly used now that the results of studies by Dr B McD Duxbury (6 March, p 702) employing better laboratory control of dosage are available.

As many haematologists have already found, running anticoagulant clinics of 30-50 outpatients several times a week in already overcrowded pathology departments stretches resources to their utmost, and this is likely to get worse.

One solution to this problem would be for patients' samples to be accepted from outlying doctors' surgeries and transported to the laboratory by road or possibly by post. An inhibiting factor to this approach has always been the belief that prothrombin testing should be carried out on very fresh specimens.[1]

It was decided to examine how much a clinical decision to alter a patient's dosage would be affected by comparing the prothrombin time of blood (taken into a plastic tube containing 3·8% sodium citrate in the usual way) tested immediately with that tested 24 and 48 hours later.

Twenty patients attending an outpatient anticoagulant clinic were selected at random. Three samples were taken from each, and the prothrombin time measured on day 0, day 1, and day 2. The samples were left unseparated on the bench at room temperature until just before testing. A standard method, using the National (UK) Reference Laboratory technique and reagent, was used. The results are shown in the table.

Results of anticoagulant tests on fresh specimens and on specimens from the same patients after 24 and 48 hours

	Day 0	Day 1	Day 2
Mean prothrombin time (seconds)	37·5	36·3	38·1
range (seconds)	26–110	25–104	27–107
Mean BCR (British Corrected Ratio)	2·88	2·79	2·93
Range BCR	2·00–8·46	1·96–7·96	2·08–8·19

The therapeutic range used in this laboratory is 2·0–4·0.

As is well established, the prothrombin time initially shortened and then lengthened over the 48 hour period. In no case, however, was the change sufficient to have caused a different therapeutic decision to have been made. It is therefore suggested that consideration be given to a "postal-type" service for those patients who find it difficult to get to the laboratory and whose doctors are willing to send specimens by whatever route is available.

It is recognised that this is a less than perfect solution in that it is always best for the haematologist to discuss the possible reason for an out-of-range result with the patient direct. The pressure on laboratory outpatient resources is now such, however, that we may have to opt for a less satisfactory way of working.

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[1] Dacie JV, Lewis SM. *Practical haematology*. Edinburgh: Churchill Livingstone, 1975:331.

SIR,—The paper concerning therapeutic control of anticoagulant treatment by Dr B McD Duxbury (6 March, p 702) serves an important purpose in stressing the importance of "therapeutic quality control." Two disturbing aspects of the paper, however, are the statement that anticoagulant treatment is not cost-effective and the very poor and erratic anticoagulant control in the group receiving such drugs for 12 weeks after discharge from hospital.

To state that anticoagulant treatment is not cost-effective requires a critical examination of the mortality and morbidity in patients who are not treated. No references to such work are given, and no data are presented to support this statement. Even if such data were available, a decision would then need to be made as to whether cost-effectiveness should be the criterion for withholding therapy, but my major concern is that such a blanket statement might deter some readers from using anticoagulants when indicated.

When the British corrected ratio (BCR) was measured at one week in the group receiving a three-month course of anticoagulants, only 40% were within the "satisfactory range" in this study. This indicates that either anticoagulant requirements changed markedly in the first week after discharge or, more likely, that only a small proportion was adequately controlled at discharge. This is clearly unsatisfactory. Several studies have shown that the patients' warfarin requirements could be predicted by their response to an initial standard dose,[1–6] and in my experience this results in a more rapid attainment and better maintenance of adequate anticoagulation on discharge from hospital.

Finally, it is difficult to understand the apparent cyclical nature in the number of patients maintained in the satisfactory range, this always being greatest during the first week of the month. Such findings suggest that although the BCR was measured weekly, anticoagulant dosage was only adjusted monthly, perhaps at the fourth weekly visit. Unfortunately the relevant details are not recorded, but clearly such a method of control would not be the normal clinical method. Dose adjustments should be made regularly at the early stages so that subsequent adjustments became much less necessary. Although I do not know if anticoagulant therapy is cost-effective, I do believe that use of a predictive method and more frequent early dose adjustment would reduce the cost and increase the effectiveness of such treatment.

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[1] Routledge PA, Bell SM, Davies DM, *et al. Lancet* 1977;ii:854-5.
[2] Williams DB, Kard RC. *Am J Surg* 1979;**137**:572-6.
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[4] Green PJ. *Lancet* 1979;i:829-30.
[5] Jones BR, Baran A, Reidenberg MM. *J Am Ger Soc* 1980;**28**:10-2.
[6] Sharma NK, Routledge PA, Rawlins MD, Davies DM. *Thromb Haemost* 1982 (in press).

Shortening waiting lists in orthopaedic surgery outpatient clinics

SIR,—The article by Dr R R West and Professor B McKibbin on shortening orthopaedic waiting lists (6 March, p 728) makes positive suggestions as to ways of resolving this perennial problem. I think two aspects deserve further thought.

The first relates to patients seeking new appointments for conditions for which they have already seen a consultant. In many cases the letter received by the GP from orthopaedic outpatients ends as follows: "I have not given the patient a further appointment to see me but would be happy to review the situation at your request." This is, according to patients, often accompanied by advice as they leave the clinic that, "your doctor can always send you back if you are not progressing." Under these circumstances it is not surprising that the GP is under pressure to refer again since, as is pointed out, many of the conditions are chronic. If surgeons were more direct, telling the GP that they have no more to offer, and assuring the patient that they can be just as well treated by their own doctor (which is what the article is saying) then while honesty might be more painful the unnecessary referrals, which help no one, might diminish.

Secondly, we should consider the "trivial" element, the non-attenders, since surely no-

one can believe that GPs add patients to a waiting list several months long if they know the condition will settle spontaneously. In this case it is the length of the waiting list itself which encourages referral. If a patient comes to see me with a condition which may or may not resolve spontaneously, my threshold for referral is lowered by knowing that the wait is so long. I cannot afford, on the patient's behalf, to wait three months to find out that the condition is not resolving before adding him to a list six months long. I refer early in case the condition does not settle, in a way that would be unnecessary if the delay were only one month. The fact that some of these patients improve and do not need referral should surprise no-one, especially since the term "trivial" can only be applied retrospectively. At the time of referral some of the people who do need specialist help will have had exactly the same symptoms as those labelled "trivial."

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SIR,—I was interested in the article by Dr R R West and Professor B McKibbin on orthopaedic waiting lists (6 March, p 728). With most orthopaedic surgeons I would confirm that a high proportion of patients on these long waiting lists do not really require a specialist opinion.

We should remember that referral stems from general practice, and perhaps it is there rather than in the hospital that the solution to the problem should be sought. We have recently looked at the referral patterns in the Forth Valley Area and found that the rate of referral varies by a factor of as much as 24 between GPs in similar practices. It seems very hard on the patients that we can help if their access to specialist services is blocked by a high proportion of unnecessary or inappropriate referrals from a minority of practices. Perhaps the waiting time could be reduced most effectively by subjecting the referral letters from GPs with the highest rates to close scrutiny at the time they are received.

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Last scene of all

SIR,—The letter from Dr R S Briggs and Professor M R P Hall (6 March, p 739) makes the point that the studies so far carried out have not indicated the proper place of computed tomography in the evaluation of the demented patient.

At Frenchay Hospital, where an EMI brain scanner has been available since 1974, about 10% of the patients examined by computed tomography have been referred with a clinical diagnosis of dementia; so that over 2000 of these patients have so far been examined. Patients are accepted from hospital consultants of all specialties in the area, but in the main patients in this group have been referred by psychiatrists, neurologists, geriatricians, and general physicians. The drainage population for this unit is about 2½m people. We have been impressed over the years by the considerable numbers of patients with conditions other than cerebral atrophy revealed by this examination. Causes such as glioma, metastases, meningioma, abscess, posterior fossa tumour, subdural fluid, infarcts, haemorrhage, giant aneurysm, colloid cyst, normal-pressure hydrocephalus, and so on have all been encountered and many of these cases have been treated with satisfying results.

We are at present engaged in a more detailed study of the last 500 patients referred with dementia. The data are being computerised to include age, sex, specialty of referring doctor, type of dementia, clinical signs, and computed tomography findings, so that a quick analysis can be readily obtained. The preliminary figures indicate that more than 10% of all the patients presenting to the computed tomography department with a clinical diagnosis of dementia have underlying disease other than cerebral atrophy, and that a high proportion of these are treatable.

Our initial impressions therefore confirm the value of examining this group of patients by computed tomography in that it makes a significant contribution to the clinical assessment. Further analysis is proceeding to identify those factors associated with positive computed tomography findings.

We hope to publish these data in the near future and anticipate that it might make a contribution to the understanding of the role of computed tomography in the evaluation of the demented patient.

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SIR,—Dr R S Briggs and Professor M R P Hall (6 March, p 739) take me to task over my disagreement (30 January, p 346) with Professor P H Millard's suggestion (12 December, p 1559) that elderly persons with dementia should receive computed tomography as part of a routine screening process.

All of us have cited the study from Sydney[1] and drawn different conclusions from it. I shall not mention it further except to agree with the comment on it by Briggs and Hall that it makes it: "difficult to derive any generally applicable guidelines on the value of computed tomography in unselected patients at any age." Exactly so—not a very ringing reason for their advocating routine computed tomography in elderly dementing patients.

Briggs and Hall unfortunately omit to mention the most important reason for my letter which was that Professor Millard's leading article was about the Royal College of Physician's excellent report[2] on organic mental impairment in the elderly. Indeed, they do not mention this report at all in their letter, which is a pity since it quite unambiguously advocates caution before such investigations are accepted as routine and makes a plea for "careful evaluation." For those who have not read the report but who have read the otherwise excellent article upon it by Professor Millard (and the latter must greatly outnumber the former), it would be easy to assume that the college committee had advocated routine computed tomography for elderly dementing patients, which is certainly not the case.

As I said in my earlier letter, there are many patients (including the elderly) for whom computed tomography is strongly indicated on clinical grounds, and it is important that they should have this investigation without delay. No one, however, possesses the knowledge to decide how valuable this procedure would be if applied routinely to all dementing patients. This is not, as Briggs and Hall put it, merely a "legitimate debating point" but it represents the fundamental need for all of us to try to ensure that our limited resources for coping with the ever-increasing number of demented patients are used in the best possible way for the benefit of the patients and their hard-pressed families and other carers. This is the reason why the college committee advocated "careful evaluation before they can be put forward as screening tests."

I therefore strongly support the plea for well-planned studies which will yield information on the value of computed tomography in demented patients and which will also give an indication of its cost-effectiveness in relation to those other important measures advocated in the college report.

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[1] Smith JS, Kiloh LG. *Lancet* 1981;i:824-7.
[2] College Committee on Geriatrics of the Royal College of Physicians. *J R Coll Physicians Lond* 1981;15: 141-67.

Depression after childbirth

SIR,—I was interested to read the leading article entitled "Depression after childbirth" by Professor Sydney Brandon (27 February, p 613). I do not think the relative factors could be applied to explain psychiatric morbidity in the puerperium in Asian immigrant women as most of them are excluded from such studies because of the problems of language. Two such cases are described in which social and cultural factors are of considerable importance.

Case 1—A 25-year-old Hindu Asian had come to the UK five years ago with her family and married after being in this country three years, subsequently living with her inlaws. After an uneventful pregnancy she was delivered at term of a girl and was discharged home after a week. Within a few hours of being at home, her behaviour became disturbed, and two days later she was readmitted to the maternity unit. She appeared quiet and withdrawn, expressing ideas that she and her baby were going to die. As this was interspersed with occasional outbursts of violent and purposeless behaviour she was transferred to inpatient psychiatric care, her baby remaining with her mother-in-law. A diagnosis of depression was made, and she was started on amitriptilene and given electric convulsion treatment three times. She made an excellent response to this combination, and within two weeks she was discharged to day-hospital care with her baby; in this setting she was soon helped to cope with her baby by herself. The social factors of possible relevance in this case were those of considerable isolation during the last two months of the pregnancy while staying temporarily with her father, her mother being at that time in India, together with a high expectation on the part of her husband and his family that she be delivered of a male child.

Case 2—A 44-year-old Moslem Pakistani woman came to the UK nine months ago with no knowledge of English, her own family remaining in Pakistan. She had been married for 20 years and already had four daughters aged 12, 9, 5, and 3. After an uneventful pregnancy she was delivered at term of a girl. She remained well in the early puerperium, although from about a month she complained of nightmares. At 4½ months she experienced rapid onset of depression characterised by hypochondriacal preoccupations, melodramatic religiose behaviour, and general apathy; at an